

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

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In the Case of:)	
)	
KGV Easy Leasing, dba)	
Privilege Diagnostics)	DATE: November 6, 2007
)	
Petitioner,)	App. Div. Docket No. A-07-86
))	
- v. -)	Decision No. 2130
)	
Centers for Medicare &)	
Medicaid Services.)	
)	

DECISION VACATING DISMISSAL OF REQUEST FOR HEARING
AND REMANDING CASE TO THE ADMINISTRATIVE LAW JUDGE

KGV Easy Leasing (KGV), dba Privilege Diagnostics, appeals a March 6, 2007 ruling by Administrative Law Judge Keith W. Sickendick (the ALJ) that dismissed KGV's request for hearing concerning a CMS contractor's decision to revoke KGV's Medicare billing privileges. For the reasons below, we vacate the dismissal and remand this case to the ALJ for further proceedings.

Background

On April 6, 2006, the National Heritage Insurance Co. (NHIC), a CMS contractor, notified KGV by letter that its Medicare billing privileges were being revoked effective April 21, 2006. CMS Ex. 1. The April 6, 2006 notice letter indicated that the revocation was based on NHIC's finding that KGV, an independent diagnostic testing facility (IDTF), had knowingly or with reckless disregard submitted false or fraudulent claims for payment to Medicare. Id. at 2-3. After a carrier hearing officer affirmed the revocation, KGV requested a hearing before an administrative law judge. CMS responded with a motion to dismiss the hearing request.

In support of its motion to dismiss, CMS submitted a copy of a federal court complaint filed by KGV against the Secretary of HHS, NHIC, and others. CMS Ex. 1. In that complaint,¹ KGV alleged:

In or about February 2006, confronted with the repeated and continuous denial by NHIC of approximately 70% of its claims, KGV found itself unable to financially sustain its operations, stopped providing further services, and went out of business.

Id. at 17, ¶ 71 (emphasis added). Based on this statement, CMS asserted that KGV had ceased providing IDTF services or gone out of business in February 2006, rendering the April 2006 revocation a "nullity" and KGV's appeal "moot."

In response to the motion to dismiss, KGV argued that its appeal was not moot because NHIC's fraud finding would, if unchallenged, impair or undermine its reputation as well as its ability to restart its business, re-enroll in Medicare, and collect Medicare payment for services already rendered. KGV further claimed that it never relinquished its billing privileges and that Medicare's actions forced it to stop operating.

In support of its opposition to CMS's dismissal motion, KGV submitted the December 15, 2006 declaration of its owner, Gregory Davidov. Mr. Davidov asserted that, between 2002 and 2006, NHIC denied a large percentage of KGV's Medicare claims and that KGV was in the process of challenging those payment denials through the Medicare claims appeals process. Dec. 15, 2006 Davidov Decl. ¶¶ 4-7. Mr. Davidov further asserted that because of Medicare's payment denials, KGV "stopped providing further services" in February of 2006 while "continu[ing] to proceed with the administrative review of its 2002-2003 claims as well as its 2005-2006 claims." Id. ¶ 7.

In his March 6, 2007 ruling, the ALJ granted CMS's motion to dismiss based on the following rationale:

CMS has advised me by its briefing that the purported revocation of Petitioner's PIN [i.e., the revocation of KGV's billing privileges] by NHIC was a nullity. I

¹ The complaint alleged, among other things, that NHIC had acted "negligently" in denying KGV's Medicare claims. CMS Ex. 1, at 26. The complaint was ultimately dismissed without prejudice for failure to exhaust administrative remedies.

need look no further. A provider or supplier is granted the right to appeal a revocation of its Medicare enrollment by 42 C.F.R. § 424.545. However, according to CMS the purported revocation was a nullity. Because there was no revocation of Petitioner's PIN [provider identification number], Petitioner has no right to appeal and dismissal is appropriate pursuant to 42 C.F.R. § 498.70(b).

ALJ Ruling at 2.² Thereafter, KGV retained a new attorney and concurrently filed a request for reconsideration by the ALJ and a request for review by the Board. The Board stayed its consideration of the request for review pending the ALJ's disposition of the request for reconsideration.

In its reconsideration request, KGV contended that its previous attorney had erroneously alleged (in the federal court complaint) or conceded (in responding to CMS's motion to dismiss) that KGV had stopped providing services or gone out of business in February 2006. In support of that allegation, KGV submitted what it claimed was documentary evidence of paid Medicare claims for services allegedly performed by KGV during February and March 2006. Exhibit A to KGV's May 3, 2007 Request to Vacate and for Reconsideration. (The list identifies 28 claims for services provided during March 2006; of these 28 claims, 6 are shown as having been approved for payment by Medicare.) In addition, KGV submitted documentary evidence purporting to show that it had provided services to a Medicare beneficiary on April 6, 2006, the date of NHIC's revocation notice. See Exhibit 2 to KGV's June 5, 2007 Reply to CMS's Opposition to Request for Reconsideration. KGV also submitted two additional declarations by Gregory Davidov, one of which stated:

CMS' assertion that KGV "ceased participating in the Medicare program" before the revocation is an absolute error. Although KGV's operations were greatly reduced by February of 2006, at no time did KGV stop providing services to patients. KGV had continued to participate in the Medicare program up until its PIN was revoked in April 2006. Any belief to the contrary is made erroneous by Medicare's own records, the EOB's [Explanation of Benefits]. These records clearly show that KGV was performing services all the way up to the

² Section 498.70(b) authorizes dismissal of an ALJ hearing request if the party that filed the request has no right to a hearing.

revocation of its PIN in April 2006 and not a day before. KGV finally stopped providing services only as a result of CMS revoking KGV's PIN in April 2006.

May 3, 2007 Davidov Decl. ¶ 6 (attached to KGV's May 3, 2007 Request to Vacate and for Reconsideration).³ Based on this additional evidence, KGV contended that the ALJ's dismissal ruling was based on an erroneous finding that it had stopped providing services or gone out of business in February 2006.

Without identifying or discussing the additional evidence submitted by KGV, the ALJ denied the request for reconsideration, finding that the parties had presented "no new facts that would cause me to reopen and revise my earlier decision to dismiss Petitioner's hearing request." June 25, 2007 Ruling Denying Request for Reconsideration.

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision or ruling is supported by substantial evidence in the record. The standard of review on a disputed issue of law is whether the ALJ decision or ruling is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare* (at <http://www.hhs.gov/dab/guidelines/prosupenrolmen.html>).

Discussion

The issue addressed by the ALJ is whether KGV had a right to an ALJ hearing concerning NHIC's April 2006 determination to revoke its Medicare billing privileges. The ALJ concluded that KGV had no such right. Apparently that conclusion was based on a finding that a revocation did not in fact occur during April 2006. "Because there was no revocation" in April 2006, there was no adverse determination for KGV to appeal and, thus, no right to a hearing, according to the ALJ. March 6, 2007 Ruling at 2.

Given that NHIC issued a written notice of revocation on April 6, 2006, the ALJ's finding that a revocation – i.e., an involuntary

³ The second additional Davidov declaration, dated June 6, 2007, describes his conversations with NHIC employees about the status of KGV's billing privileges. June 6, 2007 Davidov Decl. (Exhibit 1 to KGV's June 5, 2007 Reply to CMS's Opposition to Request for Reconsideration).

termination of Medicare billing privileges – did not occur in April 2006 is justified only if one of the following circumstances is true: (1) CMS rescinded the April 2006 revocation; or (2) KGV's billing privileges were terminated prior to April 2006, leaving nothing for NHIC to revoke in April 2006. There is no evidence or allegation that CMS has rescinded the April 2006 determination. Furthermore, the ALJ made no finding about whether KGV's billing privileges were in fact terminated, voluntarily or otherwise, prior to April 2006. For these reasons, the ALJ erred in concluding that KGV's billing privileges had not been revoked in April 2006. Cf. 42 C.F.R. § 498.74(a) (requiring the ALJ to issue a written decision containing findings of fact and conclusions of law); Aase Haugen Homes, Inc., DAB No. 2013 (2006) (an ALJ must make the findings necessary to resolve the material issues in a case).⁴

CMS asserts that the ALJ dismissed the hearing request because KGV ceased providing IDTF services prior to April 2006. Response Br. at 1. CMS further asserts that the dismissal "reflects the ALJ's recognition that once [KGV] ceased furnishing IDTF services in February 2006, *thereby terminating participation in the Medicare program*, it was henceforth precluded from seeking any further Medicare payments." Id. at 5 (*italics added*). However, we see nothing in the dismissal ruling indicating that the ALJ accepted, as legally valid, CMS's contention that KGV had voluntarily terminated its enrollment – and, hence, its billing privileges – prior to April 2006. The ALJ merely stated that CMS had "advised" him that NHIC's revocation was a "nullity" and that he needed to "look no further" to conclude that KGV had no right to a hearing. If anything, this wording indicates that the ALJ accepted at face value CMS's assertion that KGV's Medicare enrollment and billing privileges had been terminated prior to April 2006. Absent any pertinent written findings of fact or conclusions of law by the ALJ, we must conclude that the ALJ did not make an independent determination regarding the status of KGV's Medicare enrollment and billing privileges prior to April 21, 2006 (the effective date of the revocation).⁵

⁴ We do not here reach the issue of whether a pre-April 2006 voluntary termination of Medicare enrollment and billing privileges, assuming that such a termination occurred, would necessarily deprive KGV of a right to appeal NHIC's April 2006 determination. If necessary, the ALJ should address that issue on remand.

⁵ In denying KGV's motion for reconsideration, the ALJ
(continued...)

In its response brief, CMS asserts that, in its motion to dismiss, it made a "finding" of voluntary termination pursuant to 42 C.F.R. § 489.52(b)(3), and that the Board "has no jurisdiction" to review that finding. Response Br. at 2, 7-8. We agree that a CMS finding of voluntary termination is not listed as an "initial determination" subject to appeal under 42 C.F.R. § 498.5. See 42 C.F.R. § 498.3(b)(1)-(17). But the appealability of a voluntary termination finding is not at issue here because there is no evidence that a CMS official with proper authority actually made such a finding. Moreover, nowhere in its motion to dismiss did CMS assert that it had made a finding of voluntary termination. The motion merely asked the ALJ to find that KGV's alleged cessation of business had rendered NHIC's revocation decision a "nullity."⁶

⁵(...continued)

stated that he had previously determined that KGV had no right to appeal "because CMS had declared the revocation a nullity" (emphasis added). Like the dismissal ruling, this reasoning indicates that the ALJ did not independently evaluate the validity of CMS's assertion that KGV had voluntarily terminated its enrollment and billing privileges prior to April 2006. The only other possible explanation for this statement is that the ALJ viewed CMS's "declaration" alone as effecting a rescission of the April 2006 revocation notice, making it unnecessary to decide whether KGV had, in fact, ceased doing business or whether, as a matter of law, the cessation of business constituted a voluntary termination of Medicare enrollment and billing privileges. However, that is not how CMS views the ALJ's dismissal ruling. According to CMS, the ALJ did not accept its declaration at face value but implicitly concluded that there were, in fact, sufficient legal and factual grounds for its assertion that KGV had terminated its enrollment and billing privileges prior to April 2006. To our knowledge, CMS has not officially rescinded or withdrawn NHIC's April 2006 revocation notice, nor has it indicated in its arguments that it views the revocation as no longer having legal effect regardless of whether KGV is found to have voluntarily terminated its Medicare enrollment and billing privileges. Under these circumstances, we find the alternative explanation for the ALJ's statement that "CMS had declared the revocation a nullity" a legally inadequate ground upon which to uphold the dismissal.

⁶ The briefs supporting CMS's motion emphasized that the case did not involve "termination." Dec. 29, 2006 Reply to
(continued...)

For the record, we note that CMS's reliance on 42 C.F.R. § 489.52(b)(3) to justify its alleged voluntary termination "finding" appears misplaced.⁷ Section 489.52(b)(3) states that "cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community." Thus, the regulation on its face appears to apply only to a Medicare "provider," which, for purposes of Part 489, is defined as any one of the following: a hospital; skilled nursing facility; clinic, rehabilitation agency, or public health agency; comprehensive outpatient rehabilitation facility; hospice; critical access hospital; community mental health center; or religious nonmedical health care institution. 42 C.F.R. § 489.2(b). KGV is not any of one of these types of institutions or facilities; rather, it is a Medicare "supplier." 42 C.F.R. § 400.202 (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare" (emphasis added)). CMS has not pointed to any statute, regulation, or program manual which provides that a *supplier* is deemed to have lost or voluntarily terminated its billing privileges or Medicare enrollment at the moment it goes out of business or ceases to provide Medicare-covered services.

CMS contends that, in the event we vacate the dismissal ruling, "this matter should not proceed before the DAB, since – by its own admission – [KGV] is already engaged in a different forum where the claims-related issues underlying NHIC's move to revoke billing privileges may be thoroughly examined, i.e., the Medicare claims appeal process established by Subpart H of Part 405." Response Br. at 11. CMS overlooks KGV's subsequent attempt to demonstrate the absence of overlapping issues in the two appeals processes. See KGV's Sur-Reply to CMS's Reply (Feb. 6, 2007) at 2-4. Moreover, we are not persuaded, on this record, that the

⁶(...continued)

Petitioner's Opposition to CMS's Motion to Dismiss at 5 n.4 (stating that "there has been no termination action and no such action is before this tribunal" (emphasis in original)); Nov. 29, 2006 Memorandum in Support of CMS's Motion to Dismiss at 6 (stating that "termination is not at issue in this case" (emphasis in original)).

⁷ CMS's response brief states: "Under the governing regulations, the cessation of business resulted in the voluntary termination of petitioner's Medicare participation. 42 C.F.R. § 489.52(b)(3)." Response Br. at 1-2.

issues presented by the revocation can or would be adjudicated in the Medicare claims appeals process. We are not even certain that the Medicare claims identified in NHIC's notice of revocation are at issue in the Medicare claims appeals process. Because further clarification or record development seems necessary to resolve this contention, the ALJ should address it on remand.

Conclusion

For the reasons given, we vacate the March 6, 2007 dismissal ruling as well as the June 25, 2007 ruling denying KGV's request for reconsideration. Assuming that CMS renews its motion to dismiss on remand, the ALJ shall determine, based on all the evidence submitted (including the evidence submitted with KGV's request for reconsideration) and the appropriate legal authorities, whether KGV voluntarily terminated its Medicare enrollment and billing privileges prior to April 2006. The ALJ shall then reconsider the motion to dismiss in light of the resolution of that issue. If CMS withdraws or the ALJ denies the motion to dismiss, a hearing on the merits of KGV's appeal shall be conducted promptly.

/s/

Judith A. Ballard

/s/

Constance B. Tobias

/s/

Sheila Ann Hegy
Presiding Board Member